

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

2010

08002

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>12 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Golf Course Road</b>		d. STREET ADDRESS <b>Oakland,</b>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>—</b> Last <b>Arnold</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.	IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft coal mines</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Washington T. Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Wolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>236-03-6787</b>	
17. INFORMANT <b>Mrs. Lula Arnold</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>20 Mar. 1961</b> to <b>29 July 1961</b> that (I) (we) last saw the deceased alive on <b>19 July 1961</b> , and that death occurred at <b>1:00P.</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>B. L. Grant, M.D.</b>		22b. ADDRESS <b>Oakland, Maryland.</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/21/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		25a. REC'D BY REGISTRAR <b>JUL 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Carroll S. Hines</b>			

2014

2014

(M)

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

Case No. 14-cv-00000

IN RE: [Illegible]

Plaintiff, [Illegible]

vs.

Defendant, [Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8011

CERTIFICATE OF DEATH

Reg. Dist. No.

08003

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSVILLE</b>	
c. LENGTH OF STAY IN 1b <b>23 YRS</b>		d. STREET ADDRESS <b>1 MAIN ST.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM SAMUEL BOWER</b>		4. DATE OF DEATH Month Day Year <b>JULY 7, 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 3, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE REPAIRMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>CASSVILLE, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BOWER</b>		14. MOTHER'S MAIDEN NAME <b>DE ETTE BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>THIS</b>	
17. INFORMANT <b>Elizabeth Brown Confluence, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR FAILURE</b> DUE TO (b) <b>CEREBROVASCULAR Accident</b> DUE TO (c) <b>GENERALIZED Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JANUARY, 1959</b> , to <b>JUNE, 1961</b> , that I last saw the deceased alive on <b>FEB, 1961</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Pedro Rivera, MD</b> M.D.		ADDRESS (Street, city or town, state) <b>FRIENDSVILLE, MD</b>	
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA</b>		DATE SIGNED <b>7-7-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 9, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery Confluence, Somerset, Pa.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don Flewman, Grantsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 11 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08004											
1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>GARRETT</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accident, Md</u>				c. LENGTH OF STAY in 1b <u>10 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Accident, Md.</u>				d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Adolphus</u> Middle <u>Bowser</u> Last <u>Bowser</u>						4. DATE OF DEATH Month <u>July</u> Day <u>6th</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 31st, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Miner</u>				11. BIRTHPLACE (State or foreign country) <u>Accident Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>PETER BOWSER</u>						14. MOTHER'S MAIDEN NAME <u>JANE MC CROBIE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs. Ella Smith, Accident Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
22a. BUREL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>7/5/61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>ADDISON</u>						22d. LOCATION (City, town, or country) <u>OAK, Md.</u>					
23. FUNERAL DIRECTOR <u>Don Newman, Grantville, Md.</u>						24a. REC'D BY REGISTRAR <u>SUL 10 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hurd</u>											

5108

M



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8013

CERTIFICATE OF DEATH

08005

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. 2, Frostburg</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. 2 Frostburg</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <b>Mary</b>		Middle <b>Verna</b>		Last <b>Caton</b>		4. DATE OF DEATH Month <b>7</b>		Day <b>19</b>		Year <b>1961</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1908</b>		9. AGE (In years last birthday) <b>52/53</b>		IF UNDER 1 YEAR Months <b>52</b>		IF UNDER 24 HRS. Days <b>53</b>		Hours <b>52</b>		Min. <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Housework</b>				11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Thomas McKenzie</b>				14. MOTHER'S MAIDEN NAME <b>Cora M. Steinla</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT <b>Clifford Caton, R.F.D. 2 Frostburg, Md.</b>				Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, metastatic from Carcinoma</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>leukemia</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <b>mar</b> 19 <b>57</b> to <b>July</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.																													
22a. SIGNATURE <b>Carlton Brinsfield</b>				M.D. <b>Carlton Brinsfield, M. D.</b>				ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/>				STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>232 Baltimore Avenue Cumberland, Maryland</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/21/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Finzel Cemetery</b>				23d. LOCATION (City, town, or county) <b>Garrett County, Md.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Gurnit</b>				ADDRESS <b>Frostburg, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 24 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>																	

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CHITTING TOWN

2100

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8014

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08006

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUTTON, MARYLAND</b>	
c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>PEARL</b> Last <b>CONNELL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-1894</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED POST MISTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>NANCY ELIZABETH TEETS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ARCHIBALD WELLINGTON CONNELL - HUTTON, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Terminal -</b> DUE TO <b>174X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Uremia -</b> DUE TO <b>Arteriosclerosis - primary in nature</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>7 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 7, 1961</b> to <b>July 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1961</b> , and that death occurred at <b>P. 7:20</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Andrew E. Mance</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <b>3 July 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. ANDREW E. MANCE</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Willie Reigleton</b> ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 6 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8015

## CERTIFICATE OF DEATH

Reg. Dist. No. C8007

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN 1b <b>8 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deer Park Rt. 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppitt-Weeks Nursing Home</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Francellia Dove</b>				4. DATE OF DEATH Month Day Year <b>July 2 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 25, 1868</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Moorefield, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Moorefield, W. Va.</b>	
13. FATHER'S NAME <b>Harrison Grady</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cooper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Thomas Dove</b> Address <b>Morgantown, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Arterio sclerosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1956</b> to <b>July 2, 1961</b> , that I last saw the deceased alive on <b>July 22, 1961</b> , and that death occurred at <b>8:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>25 Alder Street</b> DATE SIGNED <b>7/5/61</b>							
ACTUAL SIGNATURE <b>E. I. Baumgartner</b> M. D.				DATE SIGNED <b>7/5/61</b>			
PHYSICIAN'S NAME (Type) <b>E. I. Baumgartner M. D.</b>				ADDRESS <b>Oakland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beverly Hills Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Westover W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Dinnich</b>				ADDRESS <b>Oakland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>UL 10 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur J. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8015  
CERTIFICATE OF DEATH  
C8008

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN TB <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 1 Box 67 Gorman, W. Va.</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Floyd Orange Gordon</b>		4. DATE OF DEATH Month Day Year <b>July 26 19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Shops</b>	
13. FATHER'S NAME <b>Gordon, Thomas William</b>		14. MOTHER'S MAIDEN NAME <b>Weaver, Flora</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-2905</b>	
17. INFORMANT <b>Wife</b>		Address <b>Route 1 Box 67 Gorman, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Respiratory Failure</b> DUE TO <b>Bronchogenic Carcinoma -</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Right Lung</b> DUE TO <b>Chronic Pericarditis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Chronic Pericarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o m p m <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1957</b> to <b>July 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1961</b> , and that death occurred at <b>3:19 A.M.</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Herbert H. Leighton</b>		22b. DATE SIGNED <b>26 July 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Herbert Leighton</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/28/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Gorman, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		24. ADDRESS <b>Oakland, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	





8017

## CERTIFICATE OF DEATH

Reg. Dist. No. 08009

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIFE</u> <u>X</u> <u>RURAL ACCIDENT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>BROWN</u> Last <u>GRIFFITH</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>18</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>COVE GARRETT CO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER BROWN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA GEORG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR Accident</u> <u>331X</u> DUE TO (b) <u>HYPERTENSION (Arterial)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>July 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Pedro Rivera</u> (M.D.)		DATE SIGNED <u>Friendsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>PEDRO RIVERA MD</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/28/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Cove GARRETT Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 31 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

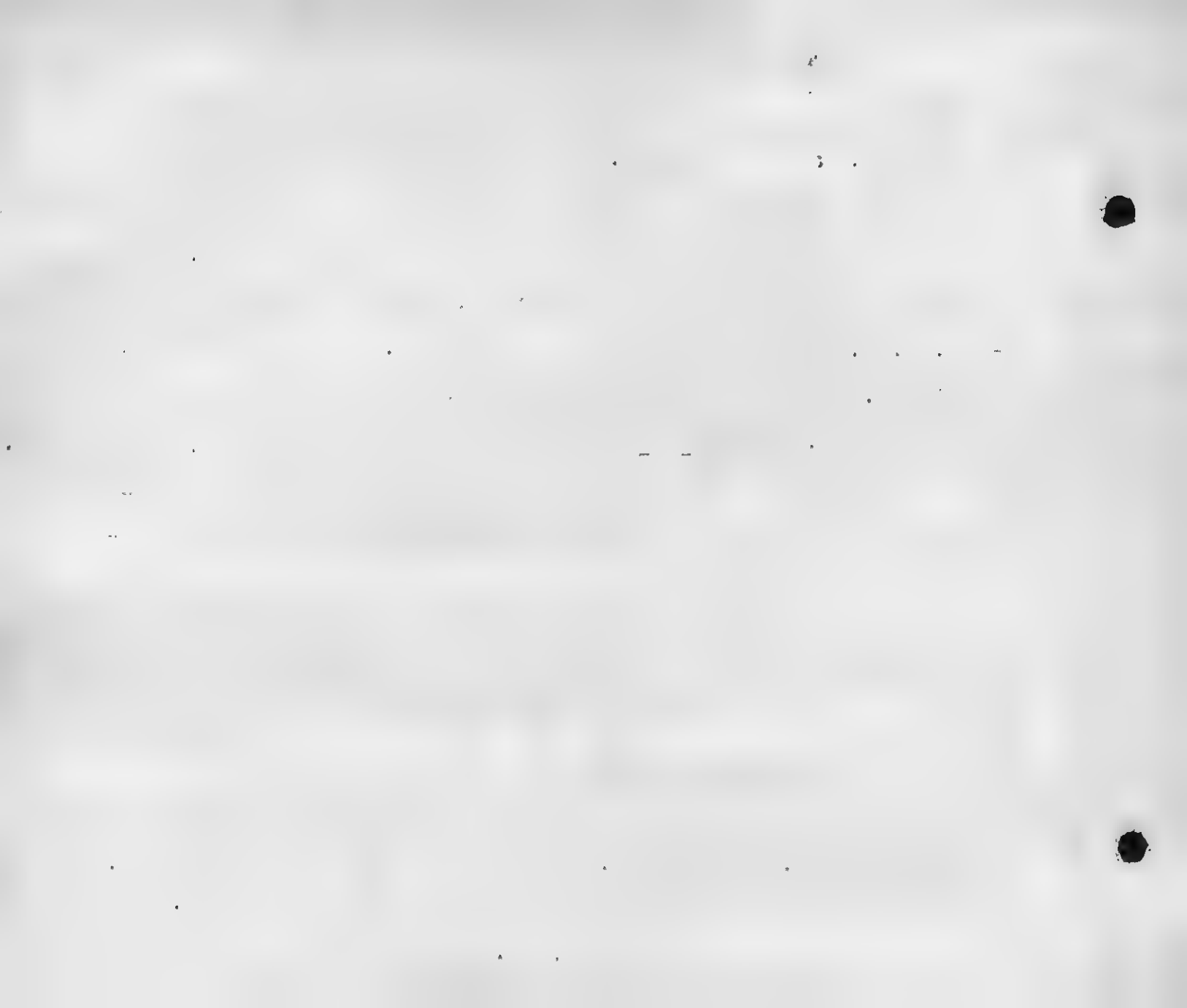
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08010

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY in 1b <b>3 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>80 Liberty Street</b>		d. STREET ADDRESS <b>80 Liberty Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Howard Anthony Grubb</b>		4. DATE OF DEATH <b>July 8, 1961</b>		Month <b>July</b> Day <b>8</b> Year <b>1961</b>	
SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>M-Sgt. U. S. Air Force, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
13. FATHER'S NAME <b>William F. Grubb</b>		14. MOTHER'S MAIDEN NAME <b>Ida Jane Shreve</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes 20 yrs. serv</b>		16. SOCIAL SECURITY NO. <b>579-12-4075</b>		17. INFORMANT <b>Ruth Grubb</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>CORONARY OCCLUSION, left</b> <b>CORONARY SCLEROSIS WITH THROMBOSIS</b>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>CORONARY OCCLUSION, left</b> <b>CORONARY SCLEROSIS WITH THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>80 Liberty St., Oakland, Md.</b>	
20f. (City or town) <b>Oakland, Md.</b>		20g. (County) <b>Garrett</b>		20h. (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 8, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pope Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Oakland, Md.</b>		22e. near Gorman, Md.		22f. (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR <i>Arthur L. Hines</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 17 '61</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8019  
CERTIFICATE OF DEATH

08011

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland.</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Mt. Lake Park.</b>	
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Guy</b> Last <b>Harvey</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathaniel B. Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Susah Moon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-34-1517</b>	
17. INFORMANT <b>Dessa C. Harvey</b>		Address <b>Oakland, Md. R D #2, Box 18</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14</b> to <b>July 9, 19 61</b> that (I) (we) lost the deceased alive on <b>July 9</b> 19 <b>61</b> and that death occurred at <b>9:50 P.</b> from the causes and on the date stated above		22a. SIGNATURE <b>Andrew E. Mance</b> M. D.	
22c. PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		22b. DATE SIGNED <b>7/14/61</b>	
22d. ADDRESS <b>Oakland, Maryland.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/12/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Aurora, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. E. Lightfoot</b>		25a. REC'D BY REGISTRAR <b>JUL 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William L. Hume</b>		25c. ADDRESS <b>Oakland, Md.</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8020 CERTIFICATE OF DEATH

C8012

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				e. STREET ADDRESS <b>S. Third Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Claude</b> Last <b>Helbig</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1961</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1907</b>	
9 AGE (In years last b. day) <b>54 yrs</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b>15</b> Min. <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Feed Store Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Oakland, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Helbig, Andrew E.</b>				14. MOTHER'S MAIDEN NAME <b>Browning, Hellie C.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, [If yes, give war or dates of service]) <b>no</b>				16. SOCIAL SECURITY NO <b>213-05-4106</b>		17. INFORMANT <b>Wife</b> Address <b>S. Third Street Oakland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.0</b> DUE TO <b>Lymphatic Leukemia Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b> DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 12:35</b> 19 <b>52</b> to <b>7-27</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7-27</b> 19 <b>61</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Andrew E. Mance</b> M.D.				22b. DATE <b>28 July 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew E. Mance</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/31/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oakland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank N. Minnich</b> ADDRESS <b>Oakland, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08013

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ACCIDENT</b> c. LENGTH OF STAY IN TB <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ACCIDENT</b> d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DONNA LYNN HUMBERSON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1961</b>		5. SEX <b>FEMALE</b>			
6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 30 1938</b>		9. AGE (In years, last birthday) <b>22</b> yrs. Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>OAKLAND GARRETT Co Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>BRUCE HUMBERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>GERALDINE FRIEND</b> Address <b>Bruce Humberston, Friendsville, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR; CEREBRAL COMPRESSION AND EDEMA</b> DUE TO (b) <b>Papilloma of Choroid Plexus; Fourth Ventricle</b> DUE TO (c) <b>"</b> INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 25, 1961</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr. M.D.</b>				Address (Street, city, town, or county) <b>Oakland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/28/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HUMBERSON</b>		22d. LOCATION (City, town, or country) (State) <b>FRIENDSVILLE GARRETT Co Mo</b>		24a. REC'D BY REGISTRAR <b>Don J. Newman, Friendsville, Md</b>	
23. FUNERAL DIRECTOR <b>Don J. Newman, Friendsville, Md</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>		24c. DATE <b>JUL 31 '61</b>			

MEDICAL CERTIFICATION

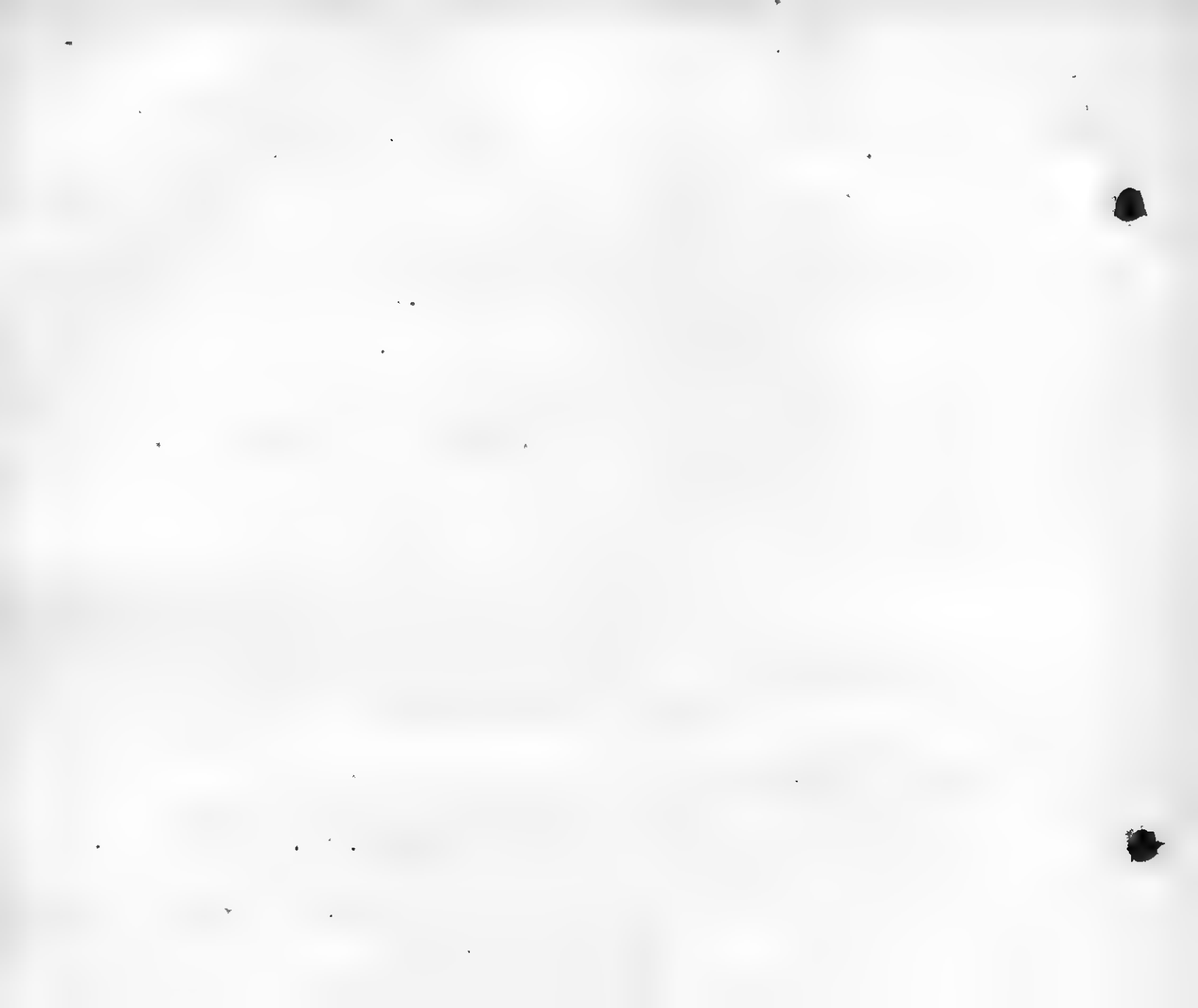


8022

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08014

1. PLACE OF DEATH a. COUNTY <u>GADSDEN</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Locust Grove</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAK-FEST NURSING HOME</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL ELIJAH JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>JULY 2ND. 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 20TH., 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Landscape</u>		11. BIRTHPLACE (State or foreign country) <u>Cresaptown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Winters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Raymond Brant, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CELEBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>14 DAYS</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>June 29th 1961</u> that (I) (we) last saw the deceased alive on <u>June 29th 1961</u> and that death occurred at <u>230A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Foster, Jr.</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. FOSTER, JR., M.D.</u>				22d. ADDRESS <u>58 2ND. ST., OAKLAND, MD. 7-2-61</u>			
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hofer</u>				25a. REC'D BY REG STRAR DATE <u>JUL 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	





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MEDICAL CERTIFICATION

24

**MARYLAND STATE DEPARTMENT OF HEALTH**

8023

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

C8015

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>4 Mo.</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>W. Va.</b>		b. COUNTY <b>Tucker</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppett Nursing Home</b>				d. STREET ADDRESS <b>85X-2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Marie</b>		First <b>Marie</b>		Middle <b>Maravia</b>		Last <b>Maravia</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1864</b>		9. AGE (In years last birthday) <b>97</b> yrs	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Tony Maravia</b>		Address <b>Davis, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GASTRIC CARCINOMA</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Thomas</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 28, 1961</b> to <b>July 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 25, 1961</b> , and that death occurred at <b>5:05 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>E. Baumgartner</b>		22b. PHYSICIAN'S NAME (Type) <b>E. BAUMGARTNER M.D.</b>		22c. ADDRESS <b>25 ALDER ST - OAKLAND - MD</b>		22d. DATE SIGNED <b>7/25/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/26/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION (City, town, or county) <b>Thomas</b>		(State) <b>W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. P. Spiggle</b>				ADDRESS <b>Davis, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



8024

CERTIFICATE OF DEATH

Reg. Dist. No. 08016

1 PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JENNINGS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JENNINGS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LIFE</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEE MEYERS</u>				4. DATE OF DEATH Month Day Year <u>JULY 30 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19, 1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAWMILL - RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>FORT HILL, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD MEYERS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET DURST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>318-16-4810</u>		INFORMANT Address <u>OLEN MEYERS, GRANTSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> <u>422.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Chronic infected diverticuli, cancer of descending colon</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14, 1957</u> to <u>July</u> , 1961, that I last saw the deceased alive on <u>7-29</u> , 19 <u>61</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. E. Atwell</u>		ADDRESS (Street, city or town, state), DATE SIGNED <u>Marysville, Pennsylvania 7/31/61</u>					
PHYSICIAN'S NAME (Type) <u>G. E. Atwell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 1, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town or county) (State) <u>GRANTSVILLE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

C8017

8025

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Christine Lillian Paugh</b>				4. DATE OF DEATH Month Day Year <b>July 3 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1904</b>		9. AGE (In years last birthday) <b>57 yrs</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alexander McVicker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Herbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>W.C. Paugh, Sr.</b>		Address <b>Kitzmiller, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Complications of fire with metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1961</b> to <b>July 3, 1961</b> , that I lost s/he the deceased alive on <b>July 3, 1961</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph Calandrella</b> M.D.				ADDRESS (Street, city or town, state) <b>Kitzmiller, Md.</b> DATE SIGNED <b>July 6-61</b>			
PHYSICIAN'S NAME (Type) <b>RALPH CALANDRELLA</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methoden Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Kyle Patton Jr.</b>				ADDRESS <b>Kitzmiller Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 10 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08018

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b> c. LENGTH OF STAY IN 1b <b>50 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Gilbert</b> Middle <b>Rippard</b> Last		4. DATE OF DEATH <b>July 26,</b> Month <b>19 61</b> Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 25, 1875</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Gilbert</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Ludwick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Dorothy Curran Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> EXAMINER'S NAME (Type)		M.D. <b>James H. Feaster, Jr., M. D.</b>		DATE SIGNED <b>7-26-61</b> Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/28/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Oakland, Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR <b>Al. Reighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>AUL 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION





8027

## CERTIFICATE OF DEATH

Reg. Dist. No.

08019

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSVILLE, MD</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ORVAL ROSS, SR.</b>				4. DATE OF DEATH Month Day Year <b>JULY 18 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 30, 1878</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STOREKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOVE FARM STORE</b>		11. BIRTHPLACE (State or foreign country) <b>VALE SUMMIT, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES ROSS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA UMBEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>—</b>		INFORMANT Address <b>Mrs Emma Ross, Friendsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR-RENAL FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>3+ yrs</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1958</b> to <b>July 1961</b> , that I last saw the deceased alive on <b>July 18, 1961</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>FRIENDSVILLE, MD</b> DATE SIGNED <b>7-19-61</b>							
ACTUAL SIGNATURE <b>Pedro Rivera, MD</b>				M.D. <b>FRIENDSVILLE, MD</b>			
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>STEELE</b>		22d. LOCATION (City, town, or county) (State) <b>FRIENDSVILLE GARRETT Co, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don Newman, Grantsville, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8028

08020

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>JOSEPH</b> Last <b>ROWAN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 21, 1894</b>
9. AGE (in years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R. R. shop</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ROWAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN <del>ROWAN</del> Lannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>705-12-4628</b>	
17. INFORMANT <b>ADA ROWAN 28 WATER ST. OAKLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Emphysema - Pulmonary Fibrosis</b> DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vascular Accident - 1 Month</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>2 Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1961</b> to <b>July 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert H. Leighton</b> M.D.		22b. DATE SIGNED <b>15 July 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. HERBERT LEIGHTON M.D.</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/18/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		25a. REC'D BY REGISTRAR <b>JUL 17 61</b>	
ADDRESS <b>Oakland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8029

08021

1 PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND, MARYLAND</b>		c. LENGTH OF STAY IN TB <b>1 DAY</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSVILLE, MARYLAND</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>ALVIN</b> Last <b>SCHROYER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>1961</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 8, 1884</b>
9. AGE (In years last birthday) yrs <b>76</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ACCIDENT, MARYLAND</b>	
11 BIRTHPLACE (State or foreign country) <b>USA</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN WESLEY SCHROYER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA SWEITZER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MRS. AMOS FRIEND (WIFE)</b>		Address <b>FRIENDSVILLE, MD.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation, Acute</b> <b>433.1</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auricular Fibrillation</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b> <b>Weeks</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>7-13-1961</b> to <b>7-14-1961</b> that (I) (we) last saw the deceased alive on <b>7-14-1961</b> and that death occurred at <b>8:40 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE <b>7-14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, M.D.</b>		22d. ADDRESS <b>OAKLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-17-61</b>	
23c. NAME OF CEMETERY, OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Accident, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert Kyle Priddy Jr. Kitzmiller, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours, after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8030

08022

1 PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MONONGAHELA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morgantown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>353 Brockway</b>	
3 NAME OF DECEASED (Type or print) First <b>MIKE</b> Middle <b>THOMAS</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED MINER</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) <b>NO</b>		17. INFORMANT <b>353 Brockway Josephine Thomas Morgantown, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> <b>570.5</b> DUE TO (b) <b>Electrolyte + Fluid Imbalance</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Intestinal Obstruction</b>		INTERVA. BETWEEN ONSET AND DEATH <b>hours</b> <b>2 days</b> <b>2 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1961</b> to <b>July 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1961</b> , and that death occurred at <b>12:50 a.m.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Herbert H. Leighton</b> M.D.		22b. DATE <b>15 July 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT. H. LEIGHTON, M.D.</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/17/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>East Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Morgantown, W. Va.</b>	
24. GENERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 17 '61</b>	
25b. REG. STRAR'S SIGNATURE <b>Charles S. Hume</b>			





TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8031

08023

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>4 Hr. 50 Min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROUTE 2, OAKLAND</b> d. STREET ADDRESS <b>/</b>	
3. NAME OF DECEASED (Type or print) <b>EDGAR</b> First Middle Last		4. DATE OF DEATH <b>JULY 12, 1961</b> Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1900</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jeremaih G. Upole</b>		14. MOTHER'S MAIDEN NAME <b>Emma Beckman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-18-2356</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE; VENTRICULAR FIBRILLATION, Sudden</b> 4/0X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Mitral Stenosis; Aortic Stenosis</b> years DUE TO (c) <b>Rheumatic Valvulitis</b> Years		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Hypertrophy, Marked</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVIEWED BY (Name and address) <b>Freda M. Upole, Route 2, Oakland, Maryland</b>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
30. EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		31. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		33. DATE SIGNED <b>7-12-61</b>	
34. ADDRESS (Street, city, town, or county) <b>Oakland, Maryland</b>		35. LOCATION (City, town, or country) (State)	
36. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		37. DATE THEREOF <b>7/15/1961</b>	
38. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery</b>		39. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	
40. FUNERAL DIRECTOR <b>H.C. Leighton</b>		41. ADDRESS <b>Oakland, Md.</b>	
42. REC'D BY REGISTRAR <b>JUL 17 '61</b>		43. REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

M

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VS. AIME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08024

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LONA CONING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LONA CONING</u>	
c. LENGTH OF STAY IN <u>LIFE</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>GERALD</u> <u>WILHELM</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>7</u> <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE, 1, 1943</u>
9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JUST GRADUATED</u>	
11. BIRTHPLACE (State or foreign country) <u>GARRETT CO, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS WILHELM</u>		14. MOTHER'S MAIDEN NAME <u>HILDA MINNICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thomas Wilhelm, RD #1, Lonaconing, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7/10/61</u> <u>FRACTURED SKULL</u> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>TREE FELL AND STRUCK DECEASED IN HEAD</u>	
20c. TIME OF INJURY Month, Day, Year Hour min. <u>1:30</u> p.m. <u>7-7</u> 19 <u>61</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> el work <input checked="" type="checkbox"/> el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>		20f. (City or town) (County) (State) <u>RURAL LONA CONING GARRETT CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BLOCKER</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL GRANTSVILLE GARRETT CO MD</u>	
23. FUNERAL DIRECTOR <u>Don Newman, Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinard</u>		DATE SIGNED <u>7-7-61</u>	

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.  
(M)  
670  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, give dates 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms 1, 2, and 3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08025

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 18 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hosp.			d. STREET ADDRESS 1 1/2 Mi. West Swanton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Reese Wilson			4. DATE OF DEATH Month Day Year July 25, 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Daniel Wilson		
14. MOTHER'S MAIDEN NAME Mildred Harvey			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. no			17. INFORMANT Address Kyle Wilson Swanton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X } DUE TO Arteriosclerotic cardio-renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 week Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22. ACTUAL SIGNATURE EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. Address (Street, city, town, or county) Oak., Md. 7-25-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/1961		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	
22d. LOCATION (City, town, or county) Deer Park, Maryland.		22e. (State) Maryland.		22f. (City or town)	
22g. (County)		22h. (State)		22i. (City or town)	
22j. (County)		22k. (State)		22l. (City or town)	
22m. (County)		22n. (State)		22o. (City or town)	
22p. (County)		22q. (State)		22r. (City or town)	
22s. (County)		22t. (State)		22u. (City or town)	
22v. (County)		22w. (State)		22x. (City or town)	
22y. (County)		22z. (State)		22aa. (City or town)	
22ab. (County)		22ac. (State)		22ad. (City or town)	
22ae. (County)		22af. (State)		22ag. (City or town)	
22ah. (County)		22ai. (State)		22aj. (City or town)	
22ak. (County)		22al. (State)		22am. (City or town)	
22an. (County)		22ao. (State)		22ap. (City or town)	
22aq. (County)		22ar. (State)		22as. (City or town)	
22at. (County)		22au. (State)		22av. (City or town)	
22aw. (County)		22ax. (State)		22ay. (City or town)	
22az. (County)		22ba. (State)		22bb. (City or town)	
22bc. (County)		22bd. (State)		22be. (City or town)	
22bf. (County)		22bg. (State)		22bh. (City or town)	
22bi. (County)		22bj. (State)		22bk. (City or town)	
22bl. (County)		22bm. (State)		22bn. (City or town)	
22bo. (County)		22bp. (State)		22bq. (City or town)	
22br. (County)		22bs. (State)		22bt. (City or town)	
22bu. (County)		22bv. (State)		22bw. (City or town)	
22bx. (County)		22by. (State)		22bz. (City or town)	
22ca. (County)		22cb. (State)		22cc. (City or town)	
22cd. (County)		22ce. (State)		22cd. (City or town)	
22cf. (County)		22cf. (State)		22ce. (City or town)	
22cg. (County)		22cg. (State)		22cf. (City or town)	
22ch. (County)		22ch. (State)		22cf. (City or town)	
22ci. (County)		22ci. (State)		22cf. (City or town)	
22cj. (County)		22cj. (State)		22cf. (City or town)	
22ck. (County)		22ck. (State)		22cf. (City or town)	
22cl. (County)		22cl. (State)		22cf. (City or town)	
22cm. (County)		22cm. (State)		22cf. (City or town)	
22cn. (County)		22cn. (State)		22cf. (City or town)	
22co. (County)		22co. (State)		22cf. (City or town)	
22cp. (County)		22cp. (State)		22cf. (City or town)	
22cq. (County)		22cq. (State)		22cf. (City or town)	
22cr. (County)		22cr. (State)		22cf. (City or town)	
22cs. (County)		22cs. (State)		22cf. (City or town)	
22ct. (County)		22ct. (State)		22cf. (City or town)	
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22jf. (County)		22jf. (State)		22cf. (City or town)	
22jg. (County)		22jg. (State)		22cf. (City or town)	
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22jk. (County)		22jk. (State)		22cf. (City or town)	
22jl. (County)		22jl. (State)		22cf. (City or town)	
22jm. (County)		22jm. (State)		22cf. (City or town)	
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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8034

## CERTIFICATE OF DEATH

Reg. Dist. No.

08026

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>(RURAL) GRANTSVILLE</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) GRANTSVILLE - MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS <u>1</u>		(If rural give location) <u>—</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>RAYMOND - M - YODER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>JULY 9 - 1961</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>single</u>	<b>8. DATE OF BIRTH</b> <u>Dec 29 - 1957</u>	<b>9. AGE last birthday</b> <u>3</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>GARRETT - CO. MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>MENNO - J - YODER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MATILDA SUMMY</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MENNO - J - YODER - GRANTSVILLE - MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Brain tumor (Carcinoma)</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 months</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>—</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>—</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>—</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Malignant brain tumor (Glioblastoma) Hospital</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>Salisbury Pa.</u>		<b>21c. WHERE DID INJURY OCCUR (City or town) (County) (State)</b> <u>Salisbury Pa.</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>M.</u>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>—</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>July 9, 1961</u> , <b>to</b> <u>July 9, 1961</u> , <b>that I last saw the deceased alive on</b> <u>July 9, 1961</u> , <b>and that death occurred at</b> <u>Salisbury Pa.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Stanley M. Thomas</u>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury Pa.</u>		<b>DATE SIGNED</b> <u>7/10/61</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>JULY-12-61</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>NIVERTON - AMISH</u>		<b>LOCATION</b> (City, town, or county) (State) <u>SALISBURY - SOMERSET CO. PA.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Stanley M. Thomas</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Stanley M. Thomas</u>			
<b>DATE</b> <u>JUL 14 '61</u>							

# CERTIFICATE OF DEATH

8032



*[Faint, mostly illegible text and lines on the certificate form, including fields for name, date, and cause of death.]*

INSTRUCTIONS

THIS IS A PRELIMINARY REPORT OF DEATH TO BE FILED IN THE DEPARTMENT OF HEALTH RECORDS. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE DEPARTMENT OF HEALTH WILL BE RESPONSIBLE FOR THE CORRECTION OF ANY ERRORS. THE DEPARTMENT OF HEALTH WILL BE RESPONSIBLE FOR THE CORRECTION OF ANY ERRORS.